FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046052

Facility Name: Bement Health Care Center

Address: 601 North Morgan Street (Number) Bement (City) 61813 (Zip Code)

County: Piatt

Telephone Number: (217) 678-2191 **Fax #** (217) 678-7521

IDPA ID Number: 371346306001

Date of Initial License for Current Owners: 02/02/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	60	Skilled (SNF)	60	21,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,039	6,474	1,294	20,807	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,039	6,474	1,294	20,807	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.01%

D. How many bed-hold days during this year were paid by Public Aid?
63 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/02/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/02/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 8 and days of care provided 1,043

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	91,061	7,739		98,800		98,800	145	98,945			1
2	Food Purchase		80,992		80,992		80,992	(2,431)	78,561			2
3	Housekeeping	38,502	11,043		49,545		49,545		49,545			3
4	Laundry	40,975	5,655		46,630		46,630		46,630			4
5	Heat and Other Utilities			56,167	56,167		56,167	394	56,561			5
6	Maintenance	27,423	19,629	4,147	51,199		51,199	1,675	52,874			6
7	Other (specify):*											7
8	**TOTAL General Services**	197,961	125,058	60,314	383,333		383,333	(217)	383,116			8
	B. Health Care and Programs											
9	Medical Director			9,850	9,850		9,850		9,850			9
10	Nursing and Medical Records	444,784	36,073	900	481,757		481,757		481,757			10
10a	Therapy		138	40,352	40,490		40,490		40,490			10a
11	Activities		72		72		72		72			11
12	Social Services	22,839	30		22,869		22,869		22,869			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	467,623	36,313	51,102	555,038		555,038		555,038			16
	C. General Administration											
17	Administrative	61,643		66,539	128,182		128,182	(66,539)	61,643			17
18	Directors Fees											18
19	Professional Services			9,462	9,462		9,462	9,238	18,700			19
20	Dues, Fees, Subscriptions & Promotions			1,919	1,919		1,919	201	2,120			20
21	Clerical & General Office Expenses	18,462	2,799	22,713	43,974		43,974	10,897	54,871			21
22	Employee Benefits & Payroll Taxes			120,775	120,775		120,775	12,175	132,950			22
23	Inservice Training & Education											23
24	Travel and Seminar			251	251		251	286	537			24
25	Other Admin. Staff Transportation			35,805	35,805		35,805	2,008	37,813			25
26	Insurance-Prop.Liab.Malpractice			51,176	51,176		51,176	504	51,680			26
27	Other (specify):*											27
28	**TOTAL General Administration**	80,105	2,799	308,640	391,544		391,544	(31,230)	360,314			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	745,689	164,170	420,056	1,329,915		1,329,915	(31,447)	1,298,468			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**** See schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Bement Health Care Center #0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			41,538	41,538		41,538	10,911	52,449			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			105,882	105,882		105,882	6,696	112,578			32
33	Real Estate Taxes			34,926	34,926		34,926		34,926			33
34	Rent-Facility & Grounds							1,877	1,877			34
35	Rent-Equipment & Vehicles							368	368			35
36	Other (specify):*											36
37	**TOTAL Ownership**			182,346	182,346		182,346	19,852	202,198			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		18,773		18,773		18,773		18,773			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,850	32,850		32,850		32,850			42
43	Other (specify):* Nonallowable Costs			(34,420)	(34,420)		(34,420)	34,420				43
44	**TOTAL Special Cost Centers**		18,773	(1,570)	17,203		17,203	34,420	51,623			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	745,689	182,943	600,832	1,529,464		1,529,464	22,825	1,552,289			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,180)	2		4
5	Telephone, TV & Radio in Resident Rooms	(724)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,669	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(448)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	37,471	43		24
25	Fund Raising, Advertising and Promotional	(1,879)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Offset vending income	(521)	2		29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ 40,388		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(17,563)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (17,563)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ 22,825		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Bement Health Care Center

ID# 0046052

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Bement Health Care Center # 0046052 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	145	0	0	0	0	0	0	0	0	0	145	1
2	Food Purchase	(1,180)	0	0	0	0	0	0	0	0	0	0	(1,180)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	394	0	0	0	0	0	0	0	0	0	394	5
6	Maintenance	0	1,675	0	0	0	0	0	0	0	0	0	1,675	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,180)	2,214	0	0	0	0	0	0	0	0	0	1,034	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(66,539)	0	0	0	0	0	0	0	0	0	(66,539)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,238	0	0	0	0	0	0	0	0	0	9,238	19
20	Fees, Subscriptions & Promotions	0	201	0	0	0	0	0	0	0	0	0	201	20
21	Clerical & General Office Expenses	0	10,897	0	0	0	0	0	0	0	0	0	10,897	21
22	Employee Benefits & Payroll Taxes	0	11,445	0	0	0	0	0	0	0	0	0	11,445	22
23	Inservice Training & Education	0	286	0	0	0	0	0	0	0	0	0	286	23
24	Travel and Seminar	0	973	0	0	0	0	0	0	0	0	0	973	24
25	Other Admin. Staff Transportation	0	1,035	0	0	0	0	0	0	0	0	0	1,035	25
26	Insurance-Prop.Liab.Malpractice	0	504	0	0	0	0	0	0	0	0	0	504	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	(31,960)	0	0	0	0	0	0	0	0	0	(31,960)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,180)	(29,746)	0	0	0	0	0	0	0	0	0	(30,926)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bement Health Care Center # 0046052 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	7,669	3,242	0	0	0	0	0	0	0	0	0	10,911	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	6,696	0	0	0	0	0	0	0	0	6,696	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	1,877	0	0	0	0	0	0	0	0	1,877	34
35	Rent-Equipment & Vehicles	0	0	368	0	0	0	0	0	0	0	0	368	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	7,669	3,242	8,941	0	0	0	0	0	0	0	0	19,852	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	34,420	0	0	0	0	0	0	0	0	0	0	34,420	43
44	**TOTAL Special Cost Centers**	34,420	0	0	0	0	0	0	0	0	0	0	34,420	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	40,909	(26,504)	8,941	0	0	0	0	0	0	0	0	23,346	45

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	See Sch 6A	See Attached Schedule 6A		See Attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care Companies	0.00%	$ 145	$ 145	1
2	V	5	Utilities		Petersen Health Care Companies	0.00%	394	394	2
3	V	6	Maintenance		Petersen Health Care Companies	0.00%	1,675	1,675	3
4	V	17	Administrative	66,539	Petersen Health Care Companies	0.00%		(66,539)	4
5	V	19	Professional Services		Petersen Health Care Companies	0.00%	9,238	9,238	5
6	V	20	Dues, Fees, & Subscriptions		Petersen Health Care Companies	0.00%	201	201	6
7	V	21	Clerical & General Office		Petersen Health Care Companies	0.00%	10,897	10,897	7
8	V	22	Employee Benefits		Petersen Health Care Companies	0.00%	11,445	11,445	8
9	V	23	Inservice Training		Petersen Health Care Companies	0.00%	286	286	9
10	V	24	Travel & Seminar		Petersen Health Care Companies	0.00%	973	973	10
11	V	25	Other Admin Staff Transport.		Petersen Health Care Companies	0.00%	1,035	1,035	11
12	V	26	Insurance		Petersen Health Care Companies	0.00%	504	504	12
13	V	30	Depreciation		Petersen Health Care Companies	0.00%	3,242	3,242	13
14	Total			$ 66,539			$ 40,035	$ * (26,504)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	Interest	$	Petersen Health Care Companies	0.00%	$ 6,696	$ 6,696	15
16	V	34	Rent-Facility & Grounds		Petersen Health Care Companies	0.00%	1,877	1,877	16
17	V	35	Rent-Equipment & Vehicles		Petersen Health Care Companies	0.00%	368	368	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 8,941	$ * 8,941	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Bemet Health Care Center
Provider # 0046052
12/31/2003

Schedule 6A

VII Related Parties - Page 6 - owned 100 % by Mark Petersen

Related Nursing Homes	City	
In-State:		
Arcola Health Care Center	Arcola, IL	
Bement Health Care Center	Bement, IL	
Countryview Terrace	Louisville, IL	
Eastview Terrace	Sullivan, IL	
Havana Health Care Center	Havana, IL	
Kewanee Care Home	Kewanee, IL	
Palm Terrace of Mattoon	Mattoon, IL	
Prairie Rose Health Care Center	Pana, IL	
Robings Manor Nursing Home	Brighton, IL	
Royal Oaks Care Center	Kewanee, IL	
Sullivan Health Care Center	Sullivan, IL	
Sunset Manor Nursing Home	Canton, IL	
Out-of-State:		
Meadow Lawn Nursing Center	Davenport, IA	
Related Assisted Living		
Courtyard Estates	Kewanee, IL	
Other Related Business Entities		
Petersen Health Care Companies	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	329,224	4.5	9.00	Salary	$ 23,276	L17, C1	1
2											2
3											3
4											4
5											5
6											6
7					See attached Schedule 7A						7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 23,276		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Bement Health Care Center
Provider # 0046052
12/31/2003

Schedule 7A

VII Related Parties
C Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

Name	Arcola Health Care Center	Bement Health Care Center	Countryview Terrace	Eastview Terrace	Havana Health Care Center	Kewanee Care Center	Meadow Lawn Nursing Center	Palm Terrace of Mattoon	Prairie Rose Health Care Center	Robings Manor Nursing Home	Royal Oaks Care Center	Sullivan Health Care Center	Sunset Manor Nursing Home	TOTAL
Mark Petersen	37,699	23,276	6,197	22,462	32,710	28,962	25,443	34,589	35,181	26,725	28,388	9,151	41,717	352,500

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care Companies
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, Illinois 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	315,110	13	$ 2,200	$	20,807	$ 145	1
2	5	Utilities	Patient Days	315,110	13	5,963		20,807	394	2
3	6	Maintenance	Patient Days	315,110	13	25,373		20,807	1,675	3
4	19	Professional Services	Patient Days	315,110	13	139,914		20,807	9,238	4
5	20	Dues, Fees & Subscriptions	Patient Days	315,110	13	3,044		20,807	201	5
6	21	Clerical & General Office	Patient Days	315,110	13	165,031		20,807	10,897	6
7	22	Employee Benefits	Patient Days	315,110	13	173,328		20,807	11,445	7
8	23	Inservice Training	Patient Days	315,110	13	4,328		20,807	286	8
9	24	Travel & Seminar	Patient Days	315,110	13	14,743		20,807	973	9
10	25	Other Admin Staff Transport.	Patient Days	315,110	13	15,681		20,807	1,035	10
11	26	Insurance	Patient Days	315,110	13	7,635		20,807	504	11
12	30	Depreciation	Patient Days	315,110	13	49,093		20,807	3,242	12
13	32	Interest	Patient Days	315,110	13	101,410		20,807	6,696	13
14	34	Rent-Facility & Grounds	Patient Days	315,110	13	28,419		20,807	1,877	14
15	35	Rent-Equipment & Vehicles	Patient Days	315,110	13	5,568		20,807	368	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 741,730	$		$ 48,976	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LaSalle Bank		x	Mortgage	$1,946.56	08/31/02	$ 1,797,235	$ 1,765,811	08/01/07	varies	$ 97,689	1
2	Bank of Farmington		x	Van Purchase	$997.95	07/31/01	35,926	6,986	08/30/04	0.0875	1,475	2
3												3
4												4
5												5
	Working Capital											
6	LaSalle Bank		x	Line of Credit	Interest Only	08/31/02	155,928		08/31/03	Varies	5,692	6
7	Adkins Commercial Brokerage		x	Commission Note	$167.00	09/10/96	22,500	7,912	08/10/06	0.0900	1,026	7
8												8
9	TOTAL Facility Related				$3,111.51		$ 2,011,589	$ 1,780,709			$ 105,882	9
	B. Non-Facility Related*											
10								Home Office Allocation			6,696	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 6,696	14
15	TOTALS (line 9+line14)						$ 2,011,589	$ 1,780,709			$ 112,578	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.		$ 30,441	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2002	$ 32,667	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,226	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 32,700	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 34,926	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	28,054	8
	1999	28,964	9
	2000	29,172	10
	2001	30,442	11
	2002	32,667	12

Accrual is equal to 100 % of the 2002 real estate tax bill, rounded to the nearest $100.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bement Health Care Center COUNTY Piatt

FACILITY IDPH LICENSE NUMBER 0046052

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (217) 678-2191 FAX #: (217) 678-7521

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	01-00-07-000-609-00	Bement Health Care Center	$ 32,667.00	$ 32,667.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 32,667.00	$ 32,667.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,000 B. General Construction Type: Exterior Block Frame Wood Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	109,829	1996	$ 33,600	1
2					2
3	TOTALS	109,829		$ 33,600	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1996		$ 780,146	$ 20,004	35	$ 22,290	$ 2,286	$ 176,463	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping			1996	3,650	217	20	183	(34)	1,390	9
10	Parking Lot			1996	1,669	99	20	83	(16)	603	10
11	Driveway			1996	1,050	62	20	53	(9)	398	11
12	Painting and Remodeling			1996	3,155	141	20	158	17	1,185	12
13	Curtains			1996	4,928	220	20	246	26	1,865	13
14	Walkway			1996	361	90	20	18	(72)	138	14
15	Alarm and Fire Equipment			1996	4,437	198	20	222	24	1,684	15
16	Sign			1996	434	19	20	22	3	190	16
17	Heating and Unit Platform			1996	1,219	54	20	61	7	539	17
18	300 Gallon Tank			1997	1,370	35	20	69	34	483	18
19	Install Gas Line			1997	1,861	48	20	93	45	636	19
20	Steel Door			1997	1,170	30	20	59	29	403	20
21	New Gas Line			1997	1,875	48	20	94	46	588	21
22	Gas Water Heater			1997	5,008	128	20	250	122	1,542	22
23	Zone Line Heaters			1997	730	65	20	37	(28)	244	23
24	Zone Line Heaters			1997	754	67	20	38	(29)	241	24
25	Generator Repair			1997	6,112		20	306	306	1,862	25
26	Ase Blacktop			1998	10,062	619	20	503	(116)	2,767	26
27	Electrical Service Generator Work			1998	1,846	47	20	92	45	506	27
28	Zone Line Heaters			1998	716	63	20	36	(27)	198	28
29	Heater			1999	4,956	442	20	248	(194)	1,116	29
30	Kickplates, Handrails			1999	1,803	46	20	90	44	405	30
31	Grade Driveway and Parking Lot			1999	3,100	215	20	155	(60)	698	31
32	Parking Lot Sealant			1999	1,060	73	20	53	(20)	239	32
33	Garage			2000	8,892	228	20	445	217	1,557	33
34	Door Frame Protectors			2000	1,059	27	20	53	26	185	34
35	Nine Windows			2000	2,290	59	20	114	55	399	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Zone Line Heater	2000	$ 1,312	$ 164	20	$ 66	$ (98)	$ 231	37
38	Carpet	2001	1,297	227	7	185	(42)	464	38
39	Fire system	2001	22,829	585	39	585		1,463	39
40	Air System	2001	9,985	256	39	256		640	40
41	Fire Door	2001	825	21	39	21		53	41
42	Water Heater	2002	3,976	681	39	51	(630)	102	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 895,937	$ 25,278		$ 27,235	$ 1,957	$ 201,477	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 145,660	$ 10,211	$ 15,672	$ 5,461	10	$ 101,652	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home office allocation			3,242	3,242			74
75	TOTALS	$ 145,660	$ 10,211	$ 18,914	$ 8,703		$ 101,652	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility use	1995 Dodge Truck	2001	$ 31,500	$ 6,049	$ 6,300	$ 251	5	$ 15,750	76
77										77
78										78
79										79
80	TOTALS			$ 31,500	$ 6,049	$ 6,300	$ 251		$ 15,750	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,106,697	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 41,538	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 52,449	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,911	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 318,879	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6		Allocated from Home Office			1,877			6
7	TOTAL				$ 1,877 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A . N/A

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 368 Description: Home Office Allocation - $ 368
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
[ ] YES
[X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	1,210	$ 20,572	$	1,210	$ 20,572	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		50	1,736		50	1,736	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3, C2	hrs		1,002	18,044	138	1,002	18,182	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				15,837		15,837	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Schedule 16a						2,936		2,936	13
14	TOTAL			$	2,262	$ 40,352	$ 18,911	2,262	$ 59,263	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Bement Health Care Center
Provider #: 0046052
01/01/03 to 12/31/03

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies	Total
Laboratory	L39, C2			1,941	1,941
X-ray	L39, C2			995	995
Total			0	2,936	2,936

See Accountants' Compilation Report

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 593,985	$ 593,985	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	272,231	272,231	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,286	7,286	6
7	Other Prepaid Expenses	16,287	16,287	7
8	Accounts Receivable (owners or related parties)	554,208	554,208	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,443,997	$ 1,443,997	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	44,129	33,600	13
14	Buildings, at Historical Cost	880,293	895,937	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	191,257	177,160	16
17	Accumulated Depreciation (book methods)	(354,886)	(318,879)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 760,793	$ 787,818	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,204,790	$ 2,231,815	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 130,274	$ 130,274	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	45,953	45,953	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,700	32,700	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17a	120,250	120,250	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 329,177	$ 329,177	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	14,898	14,898	39
40	Mortgage Payable	1,765,811	1,765,811	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,780,709	$ 1,780,709	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,109,886	$ 2,109,886	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 94,904	$ 121,929	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,204,790	$ 2,231,815	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (438,746)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(95,757)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (534,503)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	642,766	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(13,359)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 629,407	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 94,904	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,092,106	1
2	Discounts and Allowances for all Levels	22,905	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,115,011	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	41,510	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 41,510	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,180	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	11,260	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,408	19
20	Radiology and X-Ray		20
21	Other Medical Services	850	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 14,698	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Schedule 19A	1,011	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,011	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,172,230	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	383,333	31
32	Health Care	555,038	32
33	General Administration	391,544	33
	B. Capital Expense		
34	Ownership	182,346	34
	C. Ancillary Expense		
35	Special Cost Centers	(15,647)	35
36	Provider Participation Fee	32,850	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,529,464	40
41	**Income before Income Taxes (line 30 minus line 40)****	642,766	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 642,766	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity is a cash basis taxpayer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 39,100	$ 18.80	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,507	4,688	81,987	17.49	3
4	Licensed Practical Nurses	4,223	4,302	60,673	14.10	4
5	Nurse Aides & Orderlies	25,721	26,438	232,724	8.80	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	22,839	10.98	11
12	Dietician					12
13	Food Service Supervisor	3,473	3,473	31,785	9.15	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,726	8,883	59,276	6.67	15
16	Dishwashers					16
17	Maintenance Workers	2,106	2,106	27,423	13.02	17
18	Housekeepers	6,129	6,156	38,502	6.25	18
19	Laundry	5,434	5,605	40,975	7.31	19
20	Administrator	1,907	1,907	38,367	20.12	20
21	Assistant Administrator					21
22	Other Administrative	137	137	23,276	169.90	22
23	Office Manager	1,008	1,008	15,243	15.12	23
24	Clerical	80	80	3,219	40.24	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca Care Plan Coord.	2,080	2,080	30,300	14.57	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	69,691	71,023	$ 745,689 *	$ 10.50	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	9,850	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	900	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 10,750		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides		N/A		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Angela Edwards	Administrator	0	$ 32,117
Armit Jacob	Administrator	0	6,250
Mark Petersen	Administrative	100	23,276
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 61,643

B. Administrative - Other

Description	Amount
Management fees - eliminated in column 7	$ 66,539
TOTAL (agree to Schedule V, line 17, col. 3)	$ 66,539
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler Melvoin & Glasser	Accounting	$ 1,500
Bush & Snyder Associates	Legal	121
ADP	Payroll	4,730
AOL	Computer services	299
Ivans	Computer services	637
Rudy Hadsall	Computer services	855
LTC Solutions	Computer services	1,320
See attached Schedule 21A		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 9,462

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 24,119
Unemployment Compensation Insurance	7,994
FICA Taxes	51,994
Employee Health Insurance	40,343
Employee Meals	730
Illinois Municipal Retirement Fund (IMRF)*	
Life insurance	5,523
401(k)	1,945
Employee relations	302
TOTAL (agree to Schedule V, line 22, col.8)	$ 132,950

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,257
Health Care Worker Background Check	634
(Indicate # of checks performed 53)	
Miscellaneous dues	229
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,120

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	37,813
Seminar Expense	251
Home office allocation	286
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 38,350

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Bement Health Care Center
Provider #: 0046052
01/01/03 to 12/31/03

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	9,462
Allocated from Management Company	
Legal	1,269
Accounting	7,969
Total (agree to Schedule V, line 19, column 8)	18,700

See Accountants' Compilation Report

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7	N/A												
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/03 Ending: 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,864** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **32,850**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **730** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,180**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **490**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli & Company** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit is currently in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Bement Health Care Cen** **09:48 AM** **11/4/2005**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	22,825	equal to	22,825	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	112,578	equal to	112,578	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	34,926	equal to	34,926	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	52,449	equal to	52,449	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	1,877	equal to	1,877	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	368	equal to	368	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	40,490	equal to	40,490	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	18,911	equal to	18,911	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	383,333	equal to	383,333	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	555,038	equal to	555,038	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	391,544	equal to	391,544	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	182,346	equal to	182,346	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	-15,647	equal to	-15,647	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	32,850	equal to	32,850	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	414,484	equal to	444,784	-30,300	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	0	equal to		0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	22,839	equal to	22,839	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	91,061	equal to	91,061	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	27,423	equal to	27,423	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	38,502	equal to	38,502	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	40,975	equal to	40,975	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	61,643	equal to	61,643	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	18,462	equal to	18,462	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	745,689	equal to	745,689	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	9,850	< or = to	9,850	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	900	< or = to	900	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to		0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	61,643	equal to	61,643	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	66,539	equal to	66,539	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	9,462	equal to	9,462	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	132,950	equal to	132,950	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	2,120	equal to	2,120	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	38,350	equal to	537	37,813	FAILED	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	32,850	equal to	32,850	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	730	< or = to	12,175	-11,445	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	730	equal to	730	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,043	equal to	1,294	-251	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-17,563	equal to	-17,563	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	1,780,709	equal to	1,780,709	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	32,700	equal to	32,700	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	33,600	equal to	33,600	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	895,937	equal to	895,937	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	177,160	equal to	177,160	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	318,879	equal to	318,879	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	94,904	equal to	94,904	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	642,766	equal to	642,766	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,204,790	equal to	2,204,790	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter Cost Center Expenses	**YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINK TO THE COST REPORT!!**		11/4/2005	09:48:07 AM		
HSA Number	4	Name	Bement Health Care Center			
Cost report period	From:	01/01/03	To:	12/31/03	Base Number	336
If this is an ICF/DD 16 facility, enter a 1 in cell C		N				
Licensed bed days:	21,900	Occupancy:	20,807	Pct. of occupancy:	95.01%	
Illinois Public Aid Support Rate		$				
Genl Services Salary/Wage:	197,961	Col 1, Line 8 ---Audit Adj:				
Genl Admin Salary/Wage	80,105	Col 1, Line 28 ---Audit Adj:	-23276			
Total Salary Wage	745,689	Col 1, Line 44 ---Audit Adj:	-23276			
Employee Benefits	132,950	Col 8, Line 22 ---Audit Adj:				
Total General Services:	383,116	Col 8, Line 8 ---Audit Adj:				
Total General Admin	360,314	Col 8, Line 28 ---Audit Adj:	-23276			

Instructions and Calculation Steps

STEP Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to your total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8	$197,961
Divided by Total Wages (Column 1, Line 44	$722,413
General service wages as percent of total wages	27.4027%
Employee Benefits (Column 10, Line 22	$132,950
Allocation of Employee Benefits to General Services Costs	$36,432
Plus Total General Services (Column 10, Line 8	$383,116
New Total General Services Cost	$419,548

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by the proportion to get the fringes amount for General Administration

3 Add the proportioned fringe amount to your total General Administration expenses

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost

General Administration Wages (Column 1, Line 28	$56,829
Divided by Total Wages (Column 1, Line 45	$722,413
General administration wages as a percent of total wages	7.8666%
Employee Benefits (Column 10, Line 22	$132,950
Allocation of Emplayee Benefits to General Admin. Cost	$10,459
Plus Total General Administration (Column 10, Line 2	$337,038
Minus Total Fringe (Column 10, Line 22	$132,950
New Total General Administration Cos	$214,547

STEP Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month	13	divided by 2 =	6.5
Beginning Day + Ending Day	32	divided by 60.8 =	0.526315789
Beginning Year + Ending Year =	206	multiplied by 6 =	1236
Sum of the three lines			1243.026316
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			336

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier	1
General Administration Multiplie	1

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table

New Total General Service Cost (Step I-A)	$419,548	
General Services Multiplier (Step II-B	1	
Updated General Services Cost		$419,548

2 Multiply New Total General Administration Cost (from Step I-B)by the appropriate multiplier from Table

New Total General Service Cost (Step I-B	$214,547	
General Administration Multiplier (Step II-B	1	
Updated General Services Cost		$214,547
3 Total Updated Support Costs (1 + 2		$634,095

STEP I Convert Total Updated Support Costs (C-3) to Per Diem Cost

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT CO	$30.48

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14

Total Support Costs (Step II, C, 3, above	$634,095
Total Patient Days (Cost Report	20,807
Support Costs per Diem	$30.48

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5 Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above by your adjusted occupancy.

Licensed Bed Days	21,900
Multiplied by	0.93
	20,367
Minus total Patient Days	20,807
	-440
One-third of difference	-147
Plus Total Patient Day	20,807
Adjusted Occupancy	20,660
Total Support Costs (Step II, C, 3, above	$634,095
Divided by Adjusted Occupany	20660
Support Costs Per Diem	$30.69

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table I

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	$37.33
Minus Support Costs Per Diem	$30.48
Difference	$6.85
Multiply the Difference by	0.5
One-Half of the Difference	$3.43
Plus Support Costs Per Diem	$30.48
Support Rate if costs are between 35th and 75th percentile	33.91

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	$37.33
Minus Support Costs Per Diem	$30.48
Difference	$6.85
Multiply the Difference by	0.5
One-Half of the Difference	$3.43
Compare one-half the difference to the profit ceiling for your HSA in Table II and	2.83
Enter the Lower of the Two Amounts	$2.830
Plus Support Costs Per Diem	$30.48
Support Rate if support costs less than 35th percentile	$33.31

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above **$33.31**

75th Percentile is	$37.33
35th Percentile is	$31.77

Table
Inflation Multipliers

Base Number	General Services Multiplie	General Administration Multiplie
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table I
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceilinc
1	40.08	32.10	4.040
2	37.33	31.77	2.830
3	34.36	29.73	2.365
4	37.33	31.77	2.830
5	32.69	27.53	2.630
6	43.80	31.76	6.070
7	43.80	31.76	6.070
8	43.80	31.76	6.070
9	39.02	30.77	4.175
10	40.08	32.10	4.040
11	35.80	29.99	2.955

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceilinc
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

Capital Rate Data
Change print Orientation!

YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LINKED TO THE COST REPORT!!!! 11/4/2005 09:48:07 AM
COSTS INCLUDED ON PAGES 12 THRU 12D START AT CELL O6

Facility Name:				ID:	**0046052**
Bement Health Care Center					
HSA No.:	?	Own or Rent? (O or R)		Own or Rent Beginning:	
IF RENTED, have facilities been continously rented from an unrelated party since prior to January 1, 1978 (Y or N): or since the first day of operation for buildings constructed since January 1, 1978?		N			
Cost Report Pd:		Licensed Beds:	60	Total Patient Days	20,807
Begin	**01/01/03**	Licensed Bed Days:	21,900	% Occupied	95.01%
End	**12/31/03**			Capital Days	20,807
1989 Property Tax COST:		(Actual dollar amount 1989 taxes)			
1991 Property Tax RATE:		(Inflated dollar amount divided by 1991 capital days)			
FY 1991 Capital Rate:		(From form 787)			

CAPITAL CALCULATIONS

	Calculation Column
A. Determine the base year for your building from Work Table A	1998
B. Determine the Building Specific historical cost per bed:	
1. Work Table A, Line 24, Column (B)	115791
2. Total licensed beds from cost report Page 2, Line 7, column 3	60
3. Line 1 divided by Line 2	$1,930
4. Regional construction inflator from Table 2	#N/A
5. Building specific historical Cost ber bed (Line 3 * Line 4, round to even $)	#N/A
C. Obtain the Uniform Building Value from Table 1	#VALUE!
D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5	
1. Building specific historical cost from Line B5	#N/A
2. Uniform building value from Line C	#VALUE!
3. Add Lines 1 and 2	#VALUE!
4. Divide by 2 to obtain average	#VALUE!
5. Enter 120% of line C	#VALUE!
6. The blended value is the lesser of Line 4 or Line 5	#VALUE!
E. Divide the blended value from step D by 339 days to obtain a per diem blended value investment	#VALUE!
F. Multiply the per diem blended value from step E by the applicable rate of return to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.13% for 1978 and older base years.)	#VALUE!
G. Add $2.50 to Line F for equipment, rent, vehicle and working capital.	2.5
H. Add Lines F & G to obtain the preliminary capital rate	#VALUE!
I. Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FY91.)	
1. Enter the FY 91 capital rate	0
2. Subtract the FY 91 property tax rate	0
3. FY 91 rate without tax	0
4. Multiply Line I3 by 115%	x 1.15%
5. Implementation capital rate	0

J. Property Tax
Property taxes are taken from the Long Term Care Property Tax Statement which was submitted to the Department of Public Aid during FY93. Reimbursement for real estate taxes is based upon the actual 1991 taxes for which the nursing homes were assessed. The formula used is a follows:

1. Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)	0
2. Divided by: Capital Days (see below)	20,807
3. Equals: Per Diem Cost	$0.00
4. Times: Property Tax Inflator (Table 3)	#N/A
5. Equals: Updated Property Tax Cost	#N/A

Capital Days
The capital days are the higher of the actual census (Page 2, Schedule III-B, Column 5, Line 14) or 93% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * .93.)

1. Total Patient Days	20,807
2. Total Licensed Bed Days * .93	20367
3. Capital Days (higher of Line 1 or Line 2)	20,807

K. Total Capital Rate for FY 94

1. Enter the greater of the simplified system rate from Line H or the implementation capital rate from Line I	#VALUE!
2. Add Property Tax from Line J5	#N/A
3. Total capital rate (add Lines 1 & 2)	#VALUE!

WORK TABLE A

		Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
1	1	0	0	0	12
2	2	0	0	0	12
3	3	0	0	0	12
4	4	0	0	0	12
5	5	0	0	0	12
6	6	96	3650	350400	12
7	7	96	1669	160224	12
8	8	96	1050	100800	12
9	9	96	3155	302880	12
10	10	96	4928	473088	12
11	11	96	361	34656	12
12	12	96	4437	425952	12
13	13	96	434	41664	12
14	14	96	1219	117024	12
15	15	97	1370	132890	12
16	16	97	1861	180517	12
17	17	97	1170	113490	12
18	18	97	1875	181875	12
19	19	97	5008	485776	12
20	20	97	730	70810	12
21	21	97	754	73138	12
22	22	97	6112	592864	12
23	23	98	10062	986076	12
24	24	98	1846	180908	12
25	25	98	716	70168	12
26	26	99	4956	490644	12
27	27	99	1803	178497	12
28	28	99	3100	306900	12
29	29	99	1060	104940	12
30	30	100	8892	889200	12
31	31	100	1059	105900	12
32	32	100	2290	229000	12
33	33	0	0	0	12
34	34	100	1312	131200	12A
35	35	101	1297	130997	12A
36	36	101	22829	2305729	12A
37	37	101	9985	1008485	12A
38	38	101	825	83325	12A
39	39	102	3976	405552	12A
40	40	0	0	0	12A
41	41	0	0	0	12A
42	42	0	0	0	12A
43	43	0	0	0	12A
44	44	0	0	0	12A
45	45	0	0	0	12A
46	46	0	0	0	12A
47	47	0	0	0	12A
48	48	0	0	0	12A
49	49	0	0	0	12A
50	50	0	0	0	12A
51	51	0	0	0	12A
52	52	0	0	0	12A
53	53	0	0	0	12A
54	54	0	0	0	12A
55	55	0	0	0	12A
56	56	0	0	0	12A
57	57	0	0	0	12A
58	58	0	0	0	12A
59	59	0	0	0	12A
60	60	0	0	0	12A
61	61	0	0	0	12A
62	62	0	0	0	12A
63	63	0	0	0	12A
64	64	0	0	0	12A
65	65	0	0	0	12A
66	66	0	0	0	12A
67	67	0	0	0	12B
68	68	0	0	0	12B
69	69	0	0	0	12B
70	70	0	0	0	12B
71	71	0	0	0	12B
72	72	0	0	0	12B
73	73	0	0	0	12B
74	74	0	0	0	12B
75	75	0	0	0	12B
76	76	0	0	0	12B
77	77	0	0	0	12B
78	78	0	0	0	12B
79	79	0	0	0	12B
80	80	0	0	0	12B
81	81	0	0	0	12B
82	82	0	0	0	12B
83	83	0	0	0	12B
84	84	0	0	0	12B
85	85	0	0	0	12B
86	86	0	0	0	12B
87	87	0	0	0	12B
88	88	0	0	0	12B
89	89	0	0	0	12B
90	90	0	0	0	12B
91	91	0	0	0	12B
92	92	0	0	0	12B
93	93	0	0	0	12B
94	94	0	0	0	12B
95	95	0	0	0	12B
96	96	0	0	0	12B

	Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
97	0	0	0	12B
98	0	0	0	12B
99	0	0	0	12C
100	0	0	0	12C
101	0	0	0	12C
102	0	0	0	12C
103	0	0	0	12C
104	0	0	0	12C
105	0	0	0	12C
106	0	0	0	12C
107	0	0	0	12C
108	0	0	0	12C
109	0	0	0	12C
110	0	0	0	12C
111	0	0	0	12C
112	0	0	0	12C
113	0	0	0	12C
114	0	0	0	12C
115	0	0	0	12C
116	0	0	0	12C
117	0	0	0	12C
118	0	0	0	12C
119	0	0	0	12C
120	0	0	0	12C
121	0	0	0	12C
122	0	0	0	12C
123	0	0	0	12C
124	0	0	0	12C
125	0	0	0	12C
126	0	0	0	12C
127	0	0	0	12C
128	0	0	0	12C
129	0	0	0	12C
130	0	0	0	12C
131	0	0	0	12D
132	0	0	0	12D
133	0	0	0	12D
134	0	0	0	12D
135	0	0	0	12D
136	0	0	0	12D
137	0	0	0	12D
138	0	0	0	12D
139	0	0	0	12D
140	0	0	0	12D
141	0	0	0	12D
142	0	0	0	12D
143	0	0	0	12D
144	0	0	0	12D
145	0	0	0	12D
146	0	0	0	12D
147	0	0	0	12D
148	0	0	0	12D
149	0	0	0	12D
150	0	0	0	12D
151	0	0	0	12D
152	0	0	0	12D
153	0	0	0	12D
154	0	0	0	12D
155	0	0	0	12D
156	0	0	0	12D
157	0	0	0	12D
158	0	0	0	12D
159	0	0	0	12D
160	0	0	0	12D
161	0	0	0	12D
162	0	0	0	12D

Base year:
Total of Column C/Total of Column B = Base Year

11445569	115791	98.84679293
Base Year =		1998

TABLE 1 error

Table 1 Uniform building Value

	Uniform Building Value	
Base year	6, 7, 8 & 9	1, 2, 3, 4, 5, 10 & 11
1970	4114	3766
1971	5348	4896
1972	6583	6026
1973	7817	7155
1974	9051	8285
1975	10285	9415
1976	11519	10545
1977	12754	11675
1978	13988	12804
1979	15222	13934
1980	16456	15064
1981	17691	16194
1982	18925	17324
1983	20159	18453
1984	21393	19583
1985	22628	20713
1986	23862	21843
1987	25096	22973
1988	26330	24102
1989	27564	25232
1990	28799	26362
1991	30033	27492
1992	31267	28622
1993	32501	29751
1994	33736	30881
1995	34970	32011
1996	36204	33141
1997	37438	34271
1998	38673	35400
1999	39907	36530
2000	41141	37660

Use the 1970 values for all years prior to 1970

TABLE 2 #N/A

Construction Inflators by year and HSA
(Note: Use the 1960 Inflators for all years prior to 1960)
(For the FY94 Nursing Facility Rate Calculation Packet)

Year	1, 2 & 10	3, 4 & 5	11	6, 7, 8 & 9
1960	6.26	6.08	6.29	6.54
1961	5.67	5.52	5.66	5.87
1962	5.67	5.52	5.66	5.87
1963	5.67	5.52	5.66	5.87
1964	5.67	5.52	5.66	5.87
1965	5.67	5.52	5.66	5.87
1966	5.36	5.23	5.35	5.55
1967	5.1	4.97	5.08	5.28
1968	4.85	4.71	4.83	5.03
1969	4.61	4.48	4.59	4.79
1970	4.38	4.25	4.36	4.56
1971	4.01	3.89	3.98	4.15
1972	3.64	3.53	3.63	3.78
1973	3.36	3.26	3.36	3.48
1974	3.08	3	3.09	3.19
1975	2.83	2.77	2.8	2.91
1976	2.73	2.65	2.74	2.82
1977	2.57	2.48	2.55	2.68
1978	2.37	2.29	2.38	2.49
1979	2.18	2.12	2.21	2.32
1980	1.96	1.92	2.02	2.08
1981	1.8	1.76	1.86	1.91
1982	1.67	1.63	1.72	1.76
1983	1.54	1.5	1.57	1.65
1984	1.51	1.47	1.55	1.62
1985	1.48	1.45	1.5	1.59
1986	1.46	1.42	1.46	1.55
1987	1.44	1.4	1.43	1.52
1988	1.4	1.36	1.39	1.46
1989	1.35	1.33	1.35	1.41
1990	1.32	1.31	1.33	1.34
1991	1.29	1.29	1.3	1.31
1992	1.26	1.26	1.27	1.26
1993	1.25	1.24	1.25	1.23
1994	1.22	1.22	1.22	1.19
1995	1.2	1.2	1.19	1.17
1996	1.12	1.11	1.13	1.12
1997	1.1	1.09	1.1	1.1
1998	1.08	1.07	1.07	1.07
1999	1.04	1.04	1.04	1.04
2000	1.02	1.02	1.02	1.03
2001	1.00	1.00	1.00	1.00
2002	1.00	1.00	1.00	1.00

TABLE 3

Property Tax Inflator

HSA	Rate
1	1.05723
2	1.0395
3	1.0333
4	1.03302
5	1.03753
6	1.02368
7	1.02054
8	1.02613
9	1.01315
10	1.0815
11	1.03527

TABLE 4

Table 2 column

HSA	Column
1	1
2	1
3	2
4	2
5	2
6	4
7	4
8	4
9	4
10	1
11	3

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	91,061	7,739	0	98,800	0	98,800	145	98,945
2. Food Purchase	0	80,992	0	80,992	0	80,992	-2,431	78,561
3. Housekeeping	38,502	11,043	0	49,545	0	49,545	0	49,545
4. Laundry	40,975	5,655	0	46,630	0	46,630	0	46,630
5. Heat and Other Utilities	0	0	56,167	56,167	0	56,167	394	56,561
6. Maintenance	27,423	19,629	4,147	51,199	0	51,199	1,675	52,874
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	197,961	125,058	60,314	383,333	0	383,333	-217	383,116
9. Medical Director	0	0	9,850	9,850	0	9,850	0	9,850
10. Nursing & Medical Records	444,784	36,073	900	481,757	0	481,757	0	481,757
10a. Therapy	0	138	40,352	40,490	0	40,490	0	40,490
11. Activities	0	72	0	72	0	72	0	72
12. Social Services	22,839	30	0	22,869	0	22,869	0	22,869
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	467,623	36,313	51,102	555,038	0	555,038	0	555,038
17. Administrative	61,643	0	66,539	128,182	0	128,182	-66,539	61,643
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	9,462	9,462	0	9,462	9,238	18,700
20. Fees, Subscriptions & Promotion	0	0	1,919	1,919	0	1,919	201	2,120
21. Clerical & General Office	18,462	2,799	22,713	43,974	0	43,974	10,897	54,871
22. Employee Benefits & Payroll	0	0	120,775	120,775	0	120,775	12,175	132,950
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	251	251	0	251	286	537
25. Other Admin. Staff Trans	0	0	35,805	35,805	0	35,805	2,008	37,813
26. Insurance-Prop.Liab.Malpractice	0	0	51,176	51,176	0	51,176	504	51,680
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	80,105	2,799	308,640	391,544	0	391,544	-31,230	360,314
29. Total General Administrative	745,689	164,170	420,056	1,329,915	0	1,329,915	-31,447	1,298,468
30. Depreciation	0	0	41,538	41,538	0	41,538	10,911	52,449
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	105,882	105,882	0	105,882	6,696	112,578
33. Real Estate	0	0	34,926	34,926	0	34,926	0	34,926
34. Rent - Facility & Grounds	0	0	0	0	0	0	1,877	1,877
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	368	368
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	182,346	182,346	0	182,346	19,852	202,198
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	18,773	0	18,773	0	18,773	0	18,773
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	32,850	32,850	0	32,850	0	32,850
43. Other (specify):*	0	0	-34,420	-34,420	0	-34,420	34,420	0
44. Total Special Cost Ce	0	18,773	-1,570	17,203	0	17,203	34,420	51,623
45. Grand Total	745,689	182,943	600,832	1,529,464	0	1,529,464	22,825	1,552,289

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	593,985	593,985
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	272,231	272,231
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	7,286	7,286
7. Other Prepaid Expenses	16,287	16,287
8. Accounts Receivable-Owner/Related Party	554,208	554,208
9. Other (specify):	0	0
10. Total current assets	1,443,997	1,443,997
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	44,129	33,600
14. Buildings, at Historical Cost	880,293	895,937
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	191,257	177,160
17. Accumulated Depreciation (book methods)	-354,886	-318,879
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	760,793	787,818
25. Total Assets	2,204,790	2,231,815
CURRENT LIABILITIES		
26. Accounts Payable	130,274	130,274
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	45,953	45,953
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	32,700	32,700
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	120,250	120,250
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	329,177	329,177
LONG TERM LIABILITES		
39.Long-Term Notes Payable	14,898	14,898
40.Mortgage Payable	1,765,811	1,765,811
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,780,709	1,780,709
46.Total Liabilities	2,109,886	2,109,886
47.Total Equity	94,904	121,929
48.Total Liabilities and Equity	2,204,790	2,231,815

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,092,106
2. Discounts and Allowances for all Levels	22,905
Subtotal - Inpatient Care	2,115,011
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	41,510
7. Oxygen	0
Subtotal - Anciliary Revenue	41,510
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	1,180
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	11,260
18. Sale of Supplies to Non-Patients	0
19. Laboratory	1,408
20. Radiologyand X-Ray	0
21. Other Medical Services	850
22. Laundry	0
Subtotal - Other Operating Revenue	14,698
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	1,011
28. Other Revenue (specify):	0
Subtotal - Other Revenue	1,011
30. Total Revenue	2,172,230
31. General Services	375,710
32. Health Care	632,690
33. General Administration	371,233
34. Ownership	258,828
35. Special Cost Centers	36,206
35. Provider Participation Fee	32,850
37. Other	0
40. Total Expenses	1,707,517
41. Income Before Income Taxes	464,713
42. Income Taxes	0
43. Net Income or Loss for the Year	464,713

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23	Provider Participation fee is linked from page 4